

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011366	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 07/16/2013
NAME OF PROVIDER OR SUPPLIER WELLINGTON AT KOKOMO THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 S DIXON RD KOKOMO, IN 46902		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Re-visit (PSR) to the investigation of Complaint IN00128564 completed on 5/30/13.</p> <p>Complaint IN00128564 - Corrected</p> <p>Survey date: July 16, 2013</p> <p>Facility number: 011366 Provider number: NA AIM number: NA</p> <p>Survey Team: Tammy Alley RN</p> <p>Census bed type: Residential: 32 Total: 32</p> <p>Census payor type: Other: 32 Total: 32</p> <p>Sample: 5</p> <p>Wellington of Kokomo was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00128564.</p> <p>Quality Review was completed by Tammy Alley RN on July 18, 2013.</p>	{R 000}			

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

YLXE12

If continuation sheet 1 of 1